Welcome to Shyong Dental Group

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Date_____

Name_____ I prefer to be called_____

SSN#_____ - _____ -_____ Birthdate_____ Email_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work phone_____ Cell_____

Single ☐ Divorced ☐ Married ☐ Widowed ☐

Emergency contact _____ Phone #_____

Whom may we thank for referring you? _____

Responsible Party

Name of person responsible for this account_____ Relationship to patient_____

Address_____

Email_____ Home phone_____ Cell Phone_____

Birthdate_____ SSN#_____ - _____ -_____

Employer_____ Work Phone_____

Is this person currently a patient in our office? _____ Yes _____ No

Insurance Information

Name of insured _____ Relationship to Patient_____

Birthdate_____ SSN# _____ - _____ - _____

Name of Employer_____ Union or local #_____

Employer Address_____ City_____ State_____ Zip_____

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Insurance Co._____ Group #_____Policy/ID_____

Ins. Co. Address_____ City_____ State_____ Zip_____

Secondary Ins.

Name of insured _____ Relationship to Patient_____

Birthdate_____ SSN# _____ - _____ - _____

Name of Employer_____ Union or local #_____

Employer address_____ City_____ State_____ Zip_____

Insurance Co._____ Group #_____Policy/ID_____

Ins. Co. Address_____ City_____ State_____ Zip_____

Patient Medical History

1. Is your current physical health ☐ Good ☐ Fair ☐ Poor
2. Are you under medical treatment now? Yes ☐ No ☐
3. Have you ever been hospitalized for any surgical operation or serious illness? Yes ☐ No ☐
4. Are you taking any medication (s)? List: _____ Yes ☐ No ☐
5. Do you smoke or use tobacco in any other form? Yes ☐ No ☐

Are you allergic to the following?

Aspirin	Yes ☐ No ☐	Erythromycin	Yes ☐ No ☐
Barbiturates	Yes ☐ No ☐	Jewelry/Metals	Yes ☐ No ☐
Codeine	Yes ☐ No ☐	Latex	Yes ☐ No ☐
Dental Anesthetics	Yes ☐ No ☐	Penicillin	Yes ☐ No ☐
Sedatives	Yes ☐ No ☐	Sulfa Drugs	Yes ☐ No ☐
Tetracycline	Yes ☐ No ☐	Other	Yes ☐ No ☐

Please List additional drugs/materials that cause allergic reaction: _____

Are you taking any of the following?

Acetaminophen	Yes ☐ No ☐	Blood Thinners	Yes ☐ No ☐
Antibiotics	Yes ☐ No ☐	Blood Pressure Medication	Yes ☐ No ☐
Antihistamines	Yes ☐ No ☐	Digitalis/Heart Medication	Yes ☐ No ☐
Aspirin	Yes ☐ No ☐	Insulin/Diabetes Drugs	Yes ☐ No ☐
Blood Thinners	Yes ☐ No ☐	Nitroglycerin	Yes ☐ No ☐
Recreational Drugs	Yes ☐ No ☐	Thyroid Medicine	Yes ☐ No ☐
Steroids/Cortisone	Yes ☐ No ☐	Tranquilizers	Yes ☐ No ☐

Do you or have you experienced the following?

Abnormal Bleeding	Yes ☐ No ☐	Psychiatric Problems	Yes ☐ No ☐
Alcohol Abuse	Yes ☐ No ☐	Congenital Heart Defect	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Difficulty Breathing	Yes ☐ No ☐

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Artificial Bones/Joints	Yes ☐ No ☐	Drug Abuse	Yes ☐ No ☐
Artificial Valves	Yes ☐ No ☐	Emphysema	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Epilepsy	Yes ☐ No ☐
Blood Transfusion	Yes ☐ No ☐	Fainting Spells	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Fever Blisters	Yes □ No □
Chemotherapy	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐
Chicken pox	Yes ☐ No ☐	Hay fever	Yes ☐ No ☐
Headaches	Yes ☐ No ☐	Heart Attack	Yes ☐ No ☐
Heart Murmur	Yes ☐ No ☐	Heart Surgery	Yes ☐ No ☐
Hemophilia	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐
Herpes	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐
HIV+/AIDS	Yes ☐ No ☐	Hospitalized	Yes ☐ No ☐
Kidney Problems	Yes ☐ No ☐	Liver Disease	Yes ☐ No ☐
Low Blood Pressure	Yes ☐ No ☐	Lupus	Yes ☐ No ☐
Mitral Valve Prolapse	Yes ☐ No ☐	Pacemaker	Yes ☐ No ☐
Radiation Treatment	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐
Scarlet Fever	Yes ☐ No ☐	Seizures	Yes ☐ No ☐
Shingles	Yes ☐ No ☐	Sickle Cell Disease	Yes ☐ No ☐
Sinus Problems	Yes ☐ No ☐	Steroid Therapy	Yes ☐ No ☐
Stroke	Yes ☐ No ☐	Thyroid Problem	Yes ☐ No ☐
Tuberculosis	Yes ☐ No ☐	Venereal Disease	Yes ☐ No ☐

Authorization and Release

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

We authorize Shyong Dental Group to contact me VIA E-mail, phone and/or text when necessary.

I certify that I am covered by _____ insurance co. and I assign directly to Shyong Dental Group all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ Date _____

Signature of patient (or parent/guardian if minor)